



## EVALUACIÓN MÉDICA DEL CONDUCTOR

(La información médica es CONFIDENCIAL, según la sección 1808.5 del CVC)

EL MÉDICO DEVUELVE EL FORMULARIO A:

**INSTRUCCIONES PARA EL CONDUCTOR:** complete este formulario al doctor que está más familiarizado con su historial de salud y condición médica actual. Asegúrese de completar y firmar la sección de historial de salud que aparece abajo, **antes** de entregar este formulario a su doctor.

ANTES DE LA FECHA INDICADA:

NOMBRE (APELLIDO, PRIMER Y SEGUNDO NOMBRE)	NO. DE LICENCIA DE MANEJAR	FECHA DE NACIMIENTO	EXPEDIENTE
DOMICILIO	CIUDAD	CÓDIGO POSTAL	NO. TEL. DEL HOGAR O DE DÍA DEL PACIENTE ( )

**EL PACIENTE DEBE COMPLETAR EL HISTORIAL DE SALUD QUE APARECE ABAJO.** (explique cualquier respuesta "afirmativa")

SI	NO
	Lesión en la cabeza, cuello o espina dorsal
	Ataque, convulsiones o desmayo
	Mareos o dolores de cabeza frecuentes
	Problema en los ojos (excepto con lentes correctivos)
	Enfermedad cardiovascular (corazón o vaso sanguíneo)
	Derrame cerebral
	Enfermedad pulmonar (incluye TB y asma)
	Estómago irritado por los nervios o úlcera
	Diabetes
	Enfermedad renal (incluyendo piedras o sangre en la orina)
	Enfermedad muscular
	Aislamiento extenso debido a una enfermedad o lesión
	Defecto permanente
	Trastorno psiquiátrico
	Cualquier otro trastorno nervioso
	Problemas con el uso del alcohol o las drogas
	Fiebre reumática
	Padecimiento de cualquier otra enfermedad
	Cualquier enfermedad mayor en los últimos 5 años
	Cualquier operación en los últimos 5 años
	Actualmente toma medicamentos

**EXPLICACIÓN:** (Incluya fecha de inicio, diagnóstico, medicamento, nombre y dirección del doctor y cualquier condición o limitación actual. Si necesita, adjunte una hoja adicional).

**Certifico bajo pena de perjurio, conforme a las leyes de California, que he proporcionara información verdadera y completa con respecto a mi salud.**

FECHA	FIRMA DEL CONDUCTOR
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X

**INSTRUCTIONS TO THE DOCTOR:** The Department of Motor Vehicles' records indicate your patient may have a condition that could affect the safe operation of a motor vehicle. In this case, the Department is concerned about the following condition(s): \_\_\_\_\_.

(To be completed by DMV hearing officer)

With your assistance, we hope to resolve the matter with a minimum of inconvenience to all concerned.

The Health History section should be completed and signed by the patient before you complete this evaluation.

Your experience and knowledge of the patient's condition, results of medical examinations, and treatment plans, will be of great value in assisting the department to determine a proper licensing decision. PLEASE ANSWER ALL QUESTIONS on this form that are applicable to your patient's condition(s). You may furnish a narrative report if you prefer, but please include all information pertinent to your patient. *The department has sole responsibility for any decision regarding the patient's driving qualifications and licensure. The department will also consider non-medical factors in reaching a decision.*

### TREATMENT BY OTHER DOCTOR(S)

IS THIS PATIENT BEING TREATED FOR ANY CONDITION BY ANOTHER DOCTOR?

Yes  No

IF YES, PLEASE INDICATE NAME OF TREATING DOCTOR(S)

CONDITION BEING TREATED

## TREATMENT UNDER YOUR SUPERVISION

DIAGNOSIS (IF THE DIAGNOSIS IS A DISORDER CHARACTERIZED BY LAPSES OF CONSCIOUSNESS, DEMENTIA, OR DIABETES, COMPLETE PAGE 3 OR 4.)

DO YOU NEED TO SEE YOUR PATIENT AT REGULAR INTERVALS? IF YES, HOW OFTEN?

Yes  No

### PROGNOSIS

IS THE CONDITION

Improving  Stable  Worsening or deteriorating  Subject to change

(IF MULTIPLE CONDITIONS, PLEASE DESCRIBE STATUS AND PROGNOSIS IN COMMENTS BELOW.)

MANIFESTATIONS: (SYMPTOMS)

(PRESENT)

(PAST)

MAY CONDITION IMPAIR VISION?

Yes  No

HOW LONG HAS THIS PERSON BEEN YOUR PATIENT?

DATE OF LAST EXAMINATION

IS YOUR PATIENT UNDER A CONTROLLED MEDICAL PROGRAM?

HOW LONG HAS CONTROL BEEN MAINTAINED?

Yes  No

IS THE PATIENT ADHERING TO THE MEDICAL REGIMEN? IF NO, PLEASE EXPLAIN:

IS THE PATIENT KNOWLEDGEABLE ABOUT THE MEDICAL CONDITION?

Yes  No

LIST THE MEDICATIONS PRESCRIBED. PLEASE INCLUDE DOSAGE AND FREQUENCY OF USE

WHEN WAS THE LAST MEDICATION CHANGE MADE?

WOULD THE SIDE EFFECTS FROM THE PRESCRIBED MEDICATIONS INTERFERE WITH THE SAFE OPERATION OF A MOTOR VEHICLE?

Yes  No If yes, please describe:

IN YOUR OPINION, DOES YOUR PATIENT'S MEDICAL CONDITION AFFECT SAFE DRIVING?

Yes  No  Uncertain

HAVE YOU ADVISED AGAINST DRIVING?

Yes  No

DOCTOR'S COMMENTS:

## LEVELS OF FUNCTIONAL IMPAIRMENTS

Functional impairments that may affect safe driving ability. Please check where applicable.

MILD MODERATE SEVERE

Visual neglect .....

Left side  Right side

Loss of upper extremity motor control ....

Left side  Right side

Loss of lower extremity motor control ....

Left side  Right side

WOULD ADAPTIVE DEVICES AID YOUR PATIENT IN COMPENSATING FOR HIS/HER DISABILITY?

Yes  No  Uncertain

IF YES, PLEASE DESCRIBE

WOULD YOU RECOMMEND A DRIVING TEST BE GIVEN BY DMV?

Yes  No  Uncertain

## LAPSE OF CONSCIOUSNESS DISORDER

PLEASE IDENTIFY THE LAPSE OF CONSCIOUSNESS DISORDER BEING REPORTED (*Type of seizure, nocturnal, isolated, syncope, blackouts, etc.*) DATE(S) OF EPISODE(S) IN THE PAST THREE YEARS

DATE OF ONSET, IF KNOWN

DATE AND TIME OF LAST EPISODE

Please indicate the impairments identified below that are presently shown by your patient.

	YES	NO	UNCERTAIN
Sporadic loss of conscious awareness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Loss of consciousness .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Impaired motor function .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>

### EFFECTS AFTER EPISODE

Confusion .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diminished concentration .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Diminished judgment .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
Memory loss .....	<input type="checkbox"/>	<input type="checkbox"/>	<input type="checkbox"/>
If medication is taken to control seizures, are the serum levels recorded? .....	<input type="checkbox"/>	<input type="checkbox"/>	
Are the serum levels medically acceptable? .....	<input type="checkbox"/>	<input type="checkbox"/>	

## DEMENTIA OR COGNITIVE IMPAIRMENTS

**Alzheimer's Disease**

**Other Dementia** (*Please describe the type of dementia below, e.g., multi-infarct, metabolic, post-traumatic.*)

HISTORY OF DISEASE, RESULTS OF TESTING, ETC.

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Using the definitions given below, please rate the severity of the following forms of cognitive impairments in this patient.

**DEFINITIONS:** Mild: Judgment is relatively intact but work or social activities are significantly impaired. Ability to safely operate a motor vehicle may or may not be impaired.  
(Based on

*DSM III-R*) Moderate: Independent living is hazardous and some degree of supervision is necessary. The individual is unable to cope with the environment and driving would be dangerous.

Severe: Activities of daily living are so impaired that continual supervision is required. This person is incapable of driving a motor vehicle.

	NONE	MILD <sup>†</sup>	MODERATE <sup>†</sup>	SEVERE <sup>†</sup>	UNCERTAIN
Memory Loss .....	<input type="checkbox"/>				
Depression, secondary to dementia	<input type="checkbox"/>				
Diminished Judgment .....	<input type="checkbox"/>				
Impaired Attention .....	<input type="checkbox"/>				
Impaired Language Skills .....	<input type="checkbox"/>				
Impaired Visual Spatial Skills .....	<input type="checkbox"/>				
Impulsive Behavior .....	<input type="checkbox"/>				
Problem Solving Deficits .....	<input type="checkbox"/>				
Loss of Awareness of Disability .....	<input type="checkbox"/>				

**OVERALL DEGREE OF IMPAIRMENT**

## DIABETES

PLEASE INDICATE THE TYPE OF DIABETES THIS PATIENT HAS

DATE OF DIAGNOSIS

Type I    Type 2    Gestational

WHAT METHOD OF TREATMENT IS REQUIRED?

Controlled diet    Oral diabetes medication    Insulin injections    Insulin pump    Other:

HAS THIS PATIENT RECEIVED DIABETES EDUCATION FROM A HEALTH CARE TEAM?

Yes    No

DOES THIS PATIENT COMPLY WITH THE PRESCRIBED TREATMENT PLAN?

Yes    No

IF NO, PLEASE EXPLAIN

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IS THE DIABETES CONTROLLED AT THIS TIME?

Yes    No

IF YES, HOW LONG HAS CONTROL BEEN MAINTAINED?

IF NO, PLEASE EXPLAIN

WHAT ARE THIS PATIENT'S FASTING BLOOD GLUCOSE LEVELS?

AFTER HOW MANY HOURS OF FASTING?

WITHIN THE LAST THREE YEARS, HAS THIS PATIENT EXPERIENCED

REASON FOR EPISODES (e.g., non-compliance w/regimen, change in condition, insulin unavailable, illness, etc.)

Hypoglycemic episodes?    Hyperglycemic episodes?

Please indicate the complications manifested by the hypoglycemic or hyperglycemic episodes and rate the severity of each.

	NONE	MILD	MODERATE	SEVERE	UNCERTAIN
Abdominal pain .....	<input type="checkbox"/>				
Cognitive deficits .....	<input type="checkbox"/>				
Confusion .....	<input type="checkbox"/>				
Confusion or disorientation .....	<input type="checkbox"/>				
Incoordination .....	<input type="checkbox"/>				
Hypoglycemic unawareness .....	<input type="checkbox"/>				
Lack of stamina .....	<input type="checkbox"/>				
Loss of consciousness .....	<input type="checkbox"/>				
Stupor .....	<input type="checkbox"/>				
Visual changes .....	<input type="checkbox"/>				
Ketoacidosis .....	<input type="checkbox"/>				
Slowed reactions .....	<input type="checkbox"/>				
Seizures .....	<input type="checkbox"/>				
Weakness or fatigue .....	<input type="checkbox"/>				
Other .....	<hr/>				

DOES THIS PATIENT MANAGE HYPOGLYCEMIC OR HYPERGLYCEMIC EPISODES WITH OR WITHOUT HELP?

With    Without

HAS THIS PATIENT'S DIABETES CAUSED ANY OF THE FOLLOWING CHRONIC COMPLICATIONS?

Visual changes    Kidney disease    Nervous system disease    Vascular disease

PLEASE DESCRIBE THE EXTENT OF THE COMPLICATIONS

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HAS THE PATIENT BEEN HOSPITALIZED WITHIN THE LAST THREE YEARS DUE TO DIABETES COMPLICATIONS?

WHAT COMPLICATIONS NECESSITATED HOSPITALIZATION?

Yes    No   If yes, please give dates:

HAS AMPUTATION BEEN NECESSARY?

Yes    No

IF YES, PLEASE EXPLAIN

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## ADDITIONAL COMMENTS BY DOCTOR

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## DECLARACIÓN CONSULTIVA DEL CONDUCTOR

Se requiere información médica conforme al fundamento legal de las Divisiones 6 y 7 del Código de Vehículos de California. Si no se proporciona la información, puede denegarse la emisión de la licencia o retirarse el privilegio de manejar.

Todos los expedientes del DMV relacionados a la condición física o mental de cualquier persona son confidenciales y no están abiertos a la inspección pública (sección 1808.5 del Código de Vehículos de California). La información que se usa para determinar las calificaciones de la capacidad para manejar, está disponible para usted y/o su representante con una autorización firmada.

*El departamento tiene la responsabilidad exclusiva de tomar cualquier decisión referente a sus calificaciones y autorización para manejar. El departamento también considerará los factores no médicos al tomar su decisión.*

### AUTORIZACIÓN DE INFORMACIÓN MÉDICA (Válida durante tres años)

DOCTOR, HOSPITAL, OR MEDICAL FACILITY (NAME AND ADDRESS)

DATE	MEDICAL RECORD/PATIENT FILE NUMBER
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**Por este medio autorizo** a mi doctor u hospital a responder a cualquier pregunta del DMV o de sus empleados, relacionada a mi condición física o mental y/o uso o abuso de drogas y/o alcohol, y para que divulgue cualquier información o expedientes relacionados al Departamento de Vehículos Motorizados o sus empleados. Cualquier gasto en el que se incurra correrá por mi cuenta y no por la del Departamento de Vehículos Motorizados.

**Por este medio autorizo** al DMV a recibir cualquier información relacionada con mi condición física o mental, al uso o abuso de drogas y/o alcohol, y a utilizar la misma para determinar si tengo o no la capacidad para manejar de forma segura un vehículo motorizado.

**NOTA:** es posible que desee sacar una copia de la Evaluación Médica del Conductor llena, para guardar en sus registros.

FIRMADO <b>X</b>	FECHA
TESTIGO	FECHA

### DOCTOR'S SIGNATURE

DOCTOR'S SIGNATURE <b>X</b>	DOCTOR'S NAME (PRINTED)	DATE
CLASSIFICATION OR SPECIALTY	MEDICAL LICENSE NUMBER	TELEPHONE NUMBER (      )